STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151524	A. BUILDING _____ B. WING _____	C 12/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REID HOSPITAL & HEALTH CARE SERVICES	**1100 REID PKWY STE 125 RICHMOND, IN 47374**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 000	INITIAL COMMENTS This visit was a hospice federal and state complaint investigation survey. Complaint IN00099170 - Unsubstantiated: lack of sufficient evidence. Survey date: December 19, 2011 Facility #: 005532 Medicaid Vendor #: 200143100A Surveyor: Susan E. Sparks, RN, PHNS Reid Hospital & Health Care Services Hospice is in compliance with the IC 16-25-3 and the Conditions of Participation 42 CFR 418.52 and 418.56 as related to this complaint. Quality Review: Joyce Elder, MSN, BSN, RN December 20, 2011	L 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.